ABDOMEN.

I. On Tumors Caused by Effusions into the Lesser Peritoneal Cavity Simulating Cysts of the Pancreas. By JORDAN LLOYD, F. R. C. S. (Birmingham). The author details two cases of injury to the pancreas followed by accumulations of fluid in the lesser peritoneal cavity and the formation of a tumor in the left hypochondriac region, extending toward the umbilicus. Postmortem examination in one case, and operative exploration in the other demonstrated that in both the tumor was due to an accumulation of fluid in the lesser peritoneal cavity. He then reviews the literature of pancreatic cysts of traumatic origin, and concludes that in these cases the diagnosis of pancreatic cyst has been made on insufficient evidence, and that all the published cases are in reality cases of fluid effusions into the lesser peritoneal sac, the result of injury to the under lying pancreas, and not cysts of the pancreas in the proper meaning of the term. He calls attention to the fact that pathological distension of the lesser peritoneum gives rise to a tumor in the left hypochondriac, epigastric, and umbilical regions of a somewhat characteristic shape, but which appears to vary from time to time in form and size according to the condition of the overlying stomach, for when the viscus is full of liquid contents it increases the area of the tumor's dulness, whilst it makes its outline less definable by palpation, and if the stomach is distended with gas the dull area becomes resonant, and apparently the tumor may disappear altogether. The colon always lies below the tumor, and never in front of or above it, as is the case in kidney enlargements. The stomach is most readily distended with gas by giving a few grains of carbonate of soda and immediately afterwards a little tartaric acid, and the colon is best distended with water by injection *per rectum*. The downward limits of this space vary in individuals according to the extent to which the two layers of the great omentum remain separate, and in such cases the sac may distend so as to occupy the loins or even to fill the whole abdominal cavity.

In these cases pain is an uncertain symptom. It has usually been paroxysmal in character, coming on at irregular intervals and continuing for variable periods. It is referred to the epigastrium, strikes through to the back, and is sometimes aggravated by the taking of food. Vomiting is usually met with. It varies very much as regards frequency and its relation to meals—it may be almost continuous for a long period, or it may come on at irregular intervals only. Emaciation is a conspicuous feature, and is more than the vomiting is sufficient to explain. Anæmia has been marked in each of the author's cases. It disappeared with surprising rapidity after operation in the patient who recovered. The dullness over the left lower ribs posteriorly is an interesting sign. The cavity could easily be tapped by a needle introduced from behind, and might give rise to the belief that the fluid was in the pleural cavity. The heart may be lifted up by the underlying tumor, so that the apex beat is raised as high as the fourth intercostal space, as was seen in his second case, and also in that recorded by Senn. This displacement might easily be wrongly attributed to the presence of fluid in the left pleura. Cardiac pulsation, too, may be transmitted to the abdominal swelling. In both of the author's cases the temperatures were subnormal throughout, although in Case 1 *post-mortem* examination showed that some amount of general peritonitis was present.

In neither of the cases did the urine at any time contain sugar, but in both a little albumen and phosphates were present.

In closing this paper Mr. Lloyd submits the following conclusions:

1. That contusions of the upper part of the abdomen may be followed by the development of a tumor in the epigastric, umbilical, and left hypochondriac regions.

2. That such tumors may be due to fluid accumulations in the lesser peritoneal cavity.

3. That when the contents of such tumors are found to have the property of rapidly converting starch into sugar, we may assume that the pancreas has been injured.

4. That many such tumors have been regarded as true retention "cysts of the pancreas," and that this opinion has been formed upon insufficient evidence.

5. That the diagnosis of distention of the lesser peritoneal cavity before operation can usually be made by the characteristic shape of the swelling.

6. That early median abdominal incision and drainage is the safe and proper treatment.—*British Med. Journ.*, Nov. 12, 1892.

II. Serous Cysts of the Mesentery. By Dr. TERILLON (Paris). The difficulties of diagnosis in cases of mesenteric cysts have been considered, heretofore, almost insurmountable. T. on the basis of three observations, in this class of cases, gives the following diagnostic points.

Serous cysts are generally located in the median or lateral portion of the abdomen and are not connected with the organs which, as a rule, form the place of origin for cysts, *i. e.*, liver, kidney and ovary: in case of a very large cyst, however, the absence of such a connection is difficult of demonstration. Anteriorly or on the sides of the tumor an adhesion is found with a loop of bowel that cannot be detached: percussion, therefore, will frequently elicit a superficial tympanitic sound. The cysts can sometimes be detached, especially in a transverse direction. Their fluctuation is well marked even in cases of great tension. Their size varies. As soon as they are clinically demonstrated their contents average from three to six litres of slightly colored serum. The very excessive connections of serous cysts of the mesentery, the ætiology of which the author declares to be very obscure, renders their enucleation, as a rule, impossible or at least extremely dangerous. Simple puncturing through the abdominal walls involves danger of injury to the bowel and is often followed by recurrence. T., therefore, recommends laparotomy without previous puncture, removal of the sac as far as possible, suturing of the edges of the wound of the sac to the abdominal wound, and drainage or tampons. Several months' elapse before the resulting fistula is finally closed.

In three cases occurring in females of 18, 22 and 23 years of age, respectively, T. made the diagnosis upon the basis of the above described characteristic symptoms. Recovery followed laparotomy and suture of the cyst wall as suggested in the communication.—*Bull. et mém. de la soc. de Chirg. de Paris*, t. XVII, p. 375.